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ORIGINAL ARTICLE/ARTICLE ORIGINAL

Psychotherapy and the real-life experience: From gender dichotomy to gender diversity

Psychothérapie et expérience de vie réelle : de la dichotomie à la diversité de genre

Psicoterapia y experiencia de la vida real: De la dicotomía a la diversidad de género

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KEYWORDS
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Sex reassignment;
Real-life experience;
Therapy

Summary Treatment of gender-identity disorders is guided by standards set forth by the World Professional Association for Transgender Health (WPATH). Although not absolute, WPATH's eligibility criteria for hormone therapy and/or genital-reconstructive surgery include participation in psychotherapy. In addition, applicants for genital-reconstructive surgery are required to live at least one year full-time in the preferred gender role, a period referred to as the real-life experience (RLE). The rationale behind the RLE is to prepare the client as well as possible to make a fully informed decision about irreversible surgery. Psychotherapy can play an important role in planning the RLE and in developing resilience in coping with the inevitable psychosocial challenges. The tasks of the mental-health professional include assessment of gender identity and the impact of stigma on psychological adjustment; treatment of coexisting mental-health concerns; confronting internalized transphobia; giving permission to explore gender and sexuality; managing the gate-keeping role and offering support and advocacy during the RLE and beyond. Moreover, the desire to ''change sex'' in a binary way and the actual reality of living life as a gender variant person can be quite different; through facilitating a ''coming-out'' process, psychotherapy can aid in grieving the loss of the ideal to make room for a deeper level of acceptance of one's transgender (as opposed to male or female) identity.

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MOTS CLÉS
Transgenre ;
Transsexuel ;
Réassignation sexuelle ;
Expérience de vie réelle ;
Thérapie

Résumé Le traitement des troubles de l'identité de genre est guidé par des standards issus de l'Association mondiale professionnelle pour la santé des transgenres (WPATH). Bien que non absolus, les critères d'éligibilité à un traitement hormonal et/ou à la chirurgie de conversion sexuelle de la WPATH incluent une participation psychothérapeutique. En outre, on demande aux candidats à une chirurgie de conversion sexuelle de vivre au moins un an à temps plein dans le rôle du genre préféré, période désignée par le nom d'expérience de vie réelle (EVR). Le raisonnement sous-jacent à l'EVR est de préparer le client aussi bien que possible à prendre sa décision en étant entièrement au fait de la réalité, s'agissant d'une chirurgie irréversible. La psychothérapie peut jouer un rôle important par la projection de l'EVR et le développement de la résilience face aux inévitables défis psychosociaux. Les tâches du professionnel de santé mentale incluent l'évaluation de l'identité de genre et de l'impact de ce stigmate pendant l'ajustement psychologique ; le traitement des problèmes de santé mentale de coexistant ; la confrontation à la transphobie internalisée ; la permission d'explorer le genre et la sexualité ; la gestion du rôle tenu et l'appui et les recommandation pendant l'EVR et son contexte. De plus, le désir « de changer le sexe » d'une manière binaire et la réalité de vivre comme une personne au genre variable peuvent être tout à fait différents ; en facilitant un processus de *coming out*, la psychothérapie peut faciliter le deuil de la perte de l'idéal pour faire place à un niveau plus profond d'acceptation de son identité de transgenre (en opposition à masculine ou féminine).

PALABRAS CLAVE
Transgénero;
Transexual;
Reasignación sexual;
Experiencia de vida

Resumen El tratamiento de los trastornos de género está dirigido por estandares salidos de la Asociación Mundial Profesional para la Salud de los Trastornos de Género (WPATH). Aunque no definitivos, los criterios de eligibilidad a un tratamiento hormonal y/o a la cirugía de conversión sexual de la WPATH, incluyen una participación psicoterapéutica. Además, se pide a los candidatos a la cirugía de conversión sexual vivir al menos un año de dedicación permanente en el rol de género preferido, periodo designado por el numero de experiencia de vida real (EVR). El razonamiento subjacente al EVR es de preparar al cliente en la medida de lo posible a tomar una decisión estando enteramente acorde con la realidad, tratándose de una cirugía irreversible. La psicoterapia puede jugar un rol importante para la proyección de la experiencia de vida real y el desarrollo de la resistencia frente a los inevitables desafios psicosociales. Las tareas del profesional de salud mental incluyen la evaluación de la identidad de género y el impacto de este estigma durante el ajuste psicológico; el tratamiento de los problemas de salud mental; el tratameinto de los problemas de salud mental coexistentes; la confrontación a la transfobia internalizada; el permiso de explorar el género y la sexualidad; la gestión del rol desempeñado;el apoyo y las recomendaciones durante el EVR y su contexto. Además, el deseo de cambiar ''de sexo'' de una manera binaria y la realidad de vivir como una persona de género variable pueden ser completammente diferentes; la psicoterapia puede facilitar el duelo de la pérdida del ideal para hacer sitio a un nivel mas profundo de aceptación de su identidad de transgénero (en oposición a masculino y femenino).

French abridged version

La prise en charge des troubles de l'identité de genre (TIG) repose sur les normes de soins établis par l'Association mondiale professionnelle pour la santé des transgenre (World Professional Association for Transgender Health, WPATH) (Meyer et al., 2001). Entreprendre des séances de psychothérapie n'est pas une nécessité absolue, mais cela fait néanmoins partie des critères d'éligibilité pour une thérapie hormonale et/ou la chirurgie de reconstruction génitale. De plus, les sujets qui souhaitent subir une chirurgie de reconstruction génitale doivent vivre au moins un an à temps plein dans le rôle de genre souhaité, période qu'on appelle « expérience de vie réelle » (EVR). L'objectif de cette expérience est de préparer au mieux le sujet, afin qu'il/elle prenne une décision totalement éclairée avant une chirurgie irréversible.

Les sujets transgenres décrivent de plus en plus leurs identités de genres dans une perspective qui transcende la vision dichotomique des genres (homme—femme) et affirme leur identité et leur expérience unique de transgenre, de genre variable ou de genre hors du commun. En terme de prise en charge clinique de la dysphorie de genre, ces comportements impliquent une approche plus individualisée, centrée sur le sujet, plutôt que l'application d'un protocole standardisé de réassignation sexuelle (Bockting, 2007). Les traitements hormonaux de masculinisation/féminisation et la chirurgie de reconstruction génitale ne sont plus deux étapes d'un processus linéaire de réassignation sexuelle, mais deux options individuelles de traitement (Bockting, 1997b). L'EVR n'est plus un passage, mais une affirmation de l'identité transgenre. Plutôt que d'essayer de déterminer si le sujet est un(e) vrai(e) « transsexuel(le) » ou non et, donc, candidat(e) pour

un « changement complet » de sexe par le biais d'hormones et de chirurgie, le rôle du professionnel de santé mentale consiste aujourd'hui à faciliter le processus d'affirmation transgenre comme une situation unique et ses besoins et ceux de sa famille (Bockting and Coleman, 2007).

Les tâches du professionnel de santé mentale incluent :

- l'évaluation de l'identité de genre et l'impact de la stigmatisation sur l'ajustement psychologique ;
- le traitement des problèmes de santé mentale coexistants ;
- la confrontation avec la transphobie internalisée ;
- l'accompagnement de l'autorisation d'explorer le genre et la sexualité ;
- la gestion du rôle de gardien et le soutien pour les recommandations utiles lors de l'EVR.

Cette évaluation implique l'établissement d'une distinction entre quatre composants de l'identité sexuelle : le sexe à la naissance, l'identité de genre, le rôle sexuel social et l'orientation sexuelle. Toute personne chez qui ces quatre composants se combinent d'une manière qui déroge aux attentes de la société se retrouvera probablement stigmatisée socialement et cela peut avoir un impact profond sur son développement, son autonomie, son attachement et sa personnalité. En conséquence, pour renforcer sa résilience ; il est essentiel d'évaluer l'impact du stigma sur l'ajustement psychologique et d'inclure ces difficultés dans le protocole de traitement. Les problèmes coexistants de santé mentale peuvent comporter l'anxiété et la dépression ; la prise en charge appropriée de ces problèmes aidera le sujet à s'engager dans une thérapie et à résoudre l'expression de son affirmation (*coming out*).

Pour avoir grandi avec des sentiments de transgenre dans une société dont la vaste majorité a une vision dichotomique des genres et désapprouve la variance de genre, de nombreuses personnes transgenres ont internalisé ce sentiment, que nous désignons ici sous le terme de transphobie internalisée (similaire à l'homophobie internalisée). Chez les sujets transgenres, il est courant de souhaiter être né dans l'autre sexe, mais dans la réalité le changement de sexe de manière aussi binaire n'est ni faisable ni souhaitable. Par le biais de la facilitation d'un processus de *coming out*, la psychothérapie peut aider le sujet à faire le deuil d'un idéal pour laisser place à un niveau plus profond d'acceptation de l'identité transgenre (contrairement à celle d'homme ou de femme).

Dans le cadre du processus de *coming out*, les sujets sont encouragés à établir des liens avec leurs pairs et à trouver des communautés sur Internet ou dans la vie réelle et à tester diverses options d'expression transgenre. L'objectif est de parvenir à trouver le rôle de genre le plus confortable. Souvent, cette phase ouvre aux clients adultes à la permission d'être à nouveau un « jeune » et de s'engager dans un développement adolescent (par exemple, développer un sens de compétence et d'attraction dans un rôle de genre vécu de manière plus authentique), mais sans pour autant perdre le sens des responsabilités de la vie d'adulte (travail, famille) et des limites interpersonnelles appropriées (Bockting and Coleman, 2007).

Après une période d'exploration et d'expérimentation, la plupart des sujets sont prêts à prendre la décision d'une transition de rôle de genre et des options possibles de thérapie hormonale et/ou de chirurgie. La tâche du professionnel de santé mentale est d'assister le sujet dans une prise de décision totalement informée et de vérifier son égibilité et son état de préparation à la thérapie hormonale et/ou à la chirurgie conformément aux normes de soins de santé (Bockting and Goldberg, 2006). Le différentiel de pouvoir entre le thérapeute et le sujet est amplifié par cette fonction de gardien. Il s'agit d'un rôle privilégié attribué au thérapeute ou à l'évaluateur et qui doit être pris très au sérieux et rempli avec responsabilité. C'est souvent un véhicule de développement d'un transfert solide — utilisable pour résoudre des questions thérapeutiques clés (par exemple, colère, douleur et peur associées à la stigmatisation ; tristesse de la sensation de perte de temps ; questions liées à la famille) — ainsi que d'un contre-transfert (impuissance, codépendance).

Avant et au cours de l'EVR, le professionnel de santé mentale peut remplir un certain nombre de rôles de recommandations. Ainsi, il peut prêter assistance pour les changements légaux de nom et de sexe (généralement, sous la forme de certificats), pour la couverture de santé et les consultations et formation dans les établissements scolaires et les lieux de travail pour faciliter les changements de rôle de genre. L'affirmation publique comme transgenre est un processus qui dure toute la vie. Ainsi, pour ceux qui choisissent la solution chirurgicale, le traitement ne se termine pas après l'intervention. Le thérapeute peut être présent pour aider lors du *coming out*, des relations intimes, du fonctionnement sexuel, des remontées de douleurs morales concernant la perte de temps, du vieillissement et autres questions de transition existentielles ou de santé mentale.

English Version

Introduction

Transgender people are a diverse group of individuals who cross or transcend culturally-defined categories of gender (Bockting, 1999). They include transsexuals, cross-dressers, drag queens/kings, bigender and gender queer or questioning persons. Transsexuals are those who use hormones to masculinize or feminize their body, typically change gender roles, and desire to have or have had chest/breast and/or genital-reconstructive surgery. Access to these procedures is guided by the standards of care for gender-identity disorders set forth by the World Professional Association for Transgender Health (WPATH; Meyer et al., 2001).

Eligibility criteria for hormone therapy or genital-reconstructive surgery include a period of regular psychotherapy and/or ''Real-Life Experience'' (RLE), that is, living full-time in the desired gender role (at least three months for hormones, one year for surgery). Psychotherapy is intended to explore and find a comfortable way to express one's gender identity and treat coexisting mental health concerns that may stem from the social stigma attached to gender variance. The RLE is intended to '"test' the person's resolve, the capacity to function in the preferred gender and the adequacy of social, economic, and psychological supports'' (Meyer et al., 2001, p. 24) and to prepare the

client as well as possible to make a fully informed decision about hormones and genital-reconstructive surgery. The interpretation of the RLE has evolved over time, along the paradigm shift from a dichotomous toward a more diverse understanding of gender (Bockting, 1997a). Below each of these paradigms is reviewed before discussing the various therapeutic tasks and challenges encountered during the transgender coming-out process.

Theoretical background: gender dichotomy or diversity?

After early attempts at changing gender identity to match transsexuals' sex assigned at birth using psychodynamic or behavior modification therapy failed (Cohen-Kettenis and Kuiper, 1984; Pauly, 1965), sex reassignment became the treatment of choice for transsexualism (Benjamin, 1966). The task of the mental-health professional was to determine whether the client was a ''true'' transsexual, that is, a woman trapped in a man's body or a man trapped in a woman's body, versus a ''transvestite'', whose primary motivation for cross-dressing and spending time in the cross-gender role was sexual and/or compulsive. Prior to the 1990s, treatment of both transsexualism and transvestism followed a binary conceptualization of gender (Bockting, 1997a). Transsexuals were candidates for a change in sex; cross-sex hormones and sex reassignment surgeries were recommended, and the emphasis of the ''Real-Life Test'' was on ''passing'' in the ''opposite'' gender role. Treatment for transvestites focused on shame reduction and support to confine cross-dressing to the privacy of one's bedroom, home or sexual subculture support group; this approach essentially allowed them to spend designated time *en femme* clearly separated from time in the male role. Many of the labels transgender people used to describe their gender identity in a recent national study of the United States transgender population reflect this dichotomous view of gender (Table 1, under dichotomy).

Increasingly, however, transgender people describe their gender identities in ways that transcend a dichotomous view of gender (Table 1, under diversity). This gender diversity is consistent with examples of gender variance found historically and cross-culturally (Feinberg, 1996). The implications of a more diverse view of gender for clinical management include a more individualized, client-centered approach (rather than following a more standardized protocol of sex reassignment) that is able to accommodate a variety of gender identities and expressions; in other words, there is no one way of being transgender (Bockting, 2007). Instead of a sharp distinction between transsexualism and transvestism, a spectrum with differing developmental paths, affected by the social stigma associated with gender variance, is being increasingly recognized (Bockting and Coleman, 2007). Feminizing and masculinizing hormones and genital-reconstructive surgery are no longer two steps of one linear process of sex reassignment, but are two separate treatment options in their own right (Bockting, 1997b). The emphasis of the RLE is no longer on ''passing'', but on coming out and affirming a unique transgender identity. The motivation for genital-reconstructive surgery is less to ''change sex'' or confirm gender identity and more to improve body image and sexual functioning. Clients no longer necessarily need surgery to live and be recognized in the desired gender role. Gender identities and roles are more ambiguous, fluid or transgressive, even though they still have to intersect with a largely gender-binary world. Transgender people with varying backgrounds have come together, built communities, and established coalitions with other sexual minorities to advocate for greater visibility and equal opportunity and human rights protections (Bockting et al., 1999).

Table 1 Self-identification of gender identity among a national sample of the United States transgender population ($N = 1{,}229$).
Identification personnelle d'identité de genre dans un échantillon national de transgenre d'États-Unis.

Dichotomy
Female (MtF)[a]/Male (FtM)[b]
Female with the genitalia of a male (MtF)
Woman with a correctible birth defect
Woman with a transsexual history
Displaced male (FtM)
Boy whose syringe gives him the testosterone his balls cannot
Man-to-male (FtM)
Formerly transsexual
Survivor of transsexuality
Closet transsexual
God just made a slight error
Diversity
Transgender
I was born with a female body but I am on the male end of the gender spectrum, but I am more than just male
Post-op man of transsexual experience
75% female, no plans on surgery or hormones
Shemale
Bigender/two-spirit
Gender neutral/genderless/neither male nor female
Androgyne/ambiguous/intergendered
3rd gender
Pan-/poly-/or omni-gendered
Dynamically gendered/gender fluid
M2F dyke tomboy/butch queen/FTM Fag
(Nonbiological) intersexed or female-to-none of the above
Gender queer: female-bodied, but not necessarily female in gender and possibly not male either
In-between and beyond

The table lists responses received when transgender individuals were asked to respond to the following query: ''Please describe how you identify in terms of your transgender identity.'' Responses were categorized as reflecting dichotomy or diversity of gender (Bockting, 2007).
Le tableau liste les réponses individuelles reçues à la question suivante : « comment décrivez vous votre transidentité ». Les réponses sont classées par catégories refletant la dichotomie ou la diversité de genre.
[a] Male-to-female.
[b] Female-to-male.

Role of the mental-health professional

As stated above, the paradigm shift from dichotomy to diversity has implications for clinical management. Rather than trying to determine whether the client is a ''true'' transsexual or not and hence, a candidate for a complete ''sex change'' with hormones and surgery, the task of the mental-health professional is now one of facilitating a transgender coming-out process that is tailored toward the unique situation and needs of the individual client and his or her family (Bockting and Coleman, 2007).

The tasks of the mental-health professional include assessment, individualized treatment, advocacy, and aftercare. Assessment includes an evaluation of gender and sexual history, current self-identification and goals, body image, relationship and sexual functioning, coexisting mental-health concerns (including substance abuse), and social support (Bockting and Goldberg, 2006). A treatment plan is developed and negotiated with the client based on his or her goals and timeline, taking into account the needs of family and, if applicable, the WPATH standards of care for gender-identity disorders (Meyer et al., 2001).

Educating the client and family about current understandings of sex and gender

Mental-health treatment includes educating the client and family about current understandings of sexual and gender identity, such as distinguishing among sex assigned at birth, gender identity, social-sex role, and sexual orientation (Bockting and Goldberg, 2006; Shively and DeCecco, 1977). It is especially important to distinguish between gender identity (basic conviction of being a man, woman or transgender) and social-sex role (characteristics in personality, appearance, and behavior that are considered masculine or feminine within a given culture). For example, a transgender person may have been assigned male at birth, identify toward the female end of the spectrum in terms of gender identity, but be quite masculine in social-sex role. Explaining to both the client and family that gender identity and social sex role are two separate components of identity alleviates shame and pressure the client may feel to measure up to society's ideal of femininity and assists the family in understanding that the lack of outward femininity does not invalidate their loved one's transgender identity (Bockting, 1997b, 1999).

Performing the gate-keeping role

The requirement for a psychological evaluation and often a period of psychotherapy in order to access hormone therapy or surgery sometimes poses a challenge to engaging the client in a trusting therapeutic relationship. This ''gate-keeping'' function is often seen as a hazard. However, it can also be an asset; for example, it can be used to encourage clients to confront fears or other issues that one would rather avoid (e.g., coming out to certain family members). The power differential between therapist and client is amplified by this gate-keeping function. The gate-keeping role is a privilege with which the therapist or evaluator is entrusted that must be taken seriously and managed responsibly. It is often a vehicle for the development of strong transference that can be used to resolve key-therapeutic issues (e.g., anger, hurt, and fear associated with stigma; grief over lost time; family of origin issues) as well as counter-transference (powerlessness, codependency).

Clarifying roles and responsibilities repeatedly during therapy is essential to managing the therapist's gate-keeping role. Whether or not to change gender roles, take hormones or have surgery is first and foremost the client's decision (Bockting and Goldberg, 2006). The therapist's role is to assist the client in making a fully-informed decision, help the client develop and implement a transition plan, and ascertain the client's eligibility and readiness for hormone therapy and/or surgery in accordance with the standards of care for gender-identity disorders (Meyer et al., 2001). Ideally, the therapist is proactive in holding the client accountable to the timeline and treatment plan the client negotiated in consultation with the therapist.

Treatment of coexisting mental-health concerns

Treatment of mental-health concerns is often necessary to assist the client in engaging in the psychotherapy that is required prior to hormone therapy or surgery (Bockting and Goldberg, 2006). Gender-related stigma increases a transgender person's vulnerability to such mental-health concerns as substance abuse, anxiety, depression, and personality disorders. In a recent national study of the United States transgender population, 35% of those surveyed reported anxiety and 44% reported depression (Bockting et al., 2007). Mental-health concerns were associated with gender-related stigma, whereas pride in transgender identity and support from family and peers emerged as protective factors for mental health. Coexisting mental-health concerns need to be managed adequately so that the client is sufficiently stable to focus on the therapeutic tasks related to gender identity and expression.

Reviewing history to clarify identity and address the impact of stigma

The first phase of transgender-specific psychotherapy is reflective. The client writes and shares a detailed history of transgender feelings and expression, including how being transgender affected, firstly, the development of his or her overall identity and autonomy, secondly, relationships with family and friends, and, thirdly, dating, intimate relationships, and sexuality (Bockting and Coleman, 1992). During this phase, unresolved developmental challenges are identified and incorporated into the treatment plan. Whether or not the client was visibly gender-nonconforming in childhood often has a profound impact on his or her development (Bockting and Coleman, 2007). Feminine boys and masculine girls often become acutely aware of their differentness and experience enacted stigma in the form of harassment and ridicule; they tend to come out at an earlier age and have no choice but to develop resilience in the face of this enacted stigma. Others who are not visibly gender-nonconforming, but become aware of their transgender feelings, often succeed in keeping them private to avoid enacted stigma, yet struggle with felt stigma and are vulnerable to an identity split between a false public self that is used to fit in and a private self that often is expressed in fantasy and sexuality (Fraser, 2003). Managing this enacted or felt stigma affects individuals' development of autonomy, attachment,

and personality in different ways that require corresponding therapeutic interventions, including pharmacotherapy, individual/family/group therapy, and dialectical behavior therapy.

Confronting internalized transphobia

As a result of growing up with transgender feelings in a world that largely sees gender as a dichotomy and frowns upon gender nonconformity, many transgender people have internalized this negative appraisal, referred to here as internalized transphobia (analogous to internalized homophobia). Internalized transphobia can manifest itself in many different ways and at all stages of the transgender coming-out process (Bockting and Coleman, 2007). It is often the source of intense shame, self-hatred, and extended periods of suppression of transgender feelings. Fortunately, it is markedly less present among younger clients who have grown up during a time of greater visibility and tolerance of gender diversity. However, among older adults, it can delay seeking help. This avoidance of treatment may be related to major concerns about ''passing'' or clients feeling that they cannot ''pull off'' a ''successful'' gender-role transition. As a result, male-to-female clients may initially present with elaborate (and expensive) plans for facial feminization and body contouring (e.g., rib removal); female-to-male clients may obsess about facial hair. The wish to have been assigned the other sex and the desire to change sex fully is common, however, in reality, changing sex in such a binary way is neither attainable nor fulfilling. Through facilitating a ''coming-out'' process, psychotherapy can aid in grieving the loss of the ideal to make room for a deeper level of acceptance of one's transgender (as opposed to male or female) identity.

The task of the mental-health professional is to recognize the client's despair while simultaneously beginning to challenge ''passing'' as the overriding goal. Peer support, ideally in the form of group therapy, is invaluable in this respect. Others who are further along in their coming-out process can assist the client with putting these concerns in perspective. Confronting internalized transphobia initiates a grieving process that ultimately leads toward greater self-acceptance, authenticity, and transgender subjectivity. It also holds the promise of profound spiritual growth (Bockting and Cesaretti, 2001).

Finding a comfortable gender role and expression

The second phase of transgender-specific psychotherapy is more behavioral. The client is encouraged to connect with peers and find community on the Internet and in real life and to experiment with various options of transgender expression. The goal is to explore to eventually find a gender role and expression that is most comfortable. Oftentimes, this phase involves giving adult clients permission to be a ''kid'' again and engage in adolescent developmental tasks (i.e., developing a sense of competence and attractiveness in a more authentic gender role), yet not without losing sight of adult responsibilities (work, family) and appropriate interpersonal boundaries (Bockting and Coleman, 2007).

After a period of exploration and experimentation, most clients are ready to make a decision about a possible gender–role transition and the available options of hormone therapy and/or surgery. Making a full-time gender–role transition is in essence the start of the RLE. Taking this step is terrifying for most clients. The goal of the RLE remains to test the client's resolve and to prepare him or her for the implications of irreversible body modification through surgery. Although the RLE no longer has to conform to a binary conceptualization of gender, clients need to express their transgender identity in a way that is consistent with their long-term gender identification and goals for expression. Hence, the therapist needs to help the client distinguish between gender ambiguity (e.g., bigender or gender-queer identity) and attempts to ''back into'' a gender–role transition out of fear of rejection (by family, friends, community, school or workplace). Making incremental changes without a thought–through plan, or assuming an ambiguous gender–role when the client's ultimate goal is a complete transition, may unnecessarily prolong anxiety. Rather, the client should take responsibility for the transition by planning it carefully in consultation with the therapist and peers (e.g., in group therapy). Appendices A, B and C provide examples of guidelines based on the WPATH standards of care for gender-identity disorders to evaluate the client's eligibility and readiness for hormone therapy and/or surgery (see also Bockting and Goldberg, 2006).

Coming out to family and friends

A key part of the RLE is coming out to family and friends. Research has shown that transgender people, compared with gay, lesbian, and bisexual people, have the lowest levels of family support (Bockting et al., 2005a). This finding is particularly important, as family support has been shown to buffer the negative impact of gender-related stigma on mental health (Bockting et al., 2007).

Transgender clients often struggle with paralyzing fear when it comes to disclosure to family and friends. The therapeutic strategy is to acknowledge this fear, yet counsel the client to ''do it anyway'' by taking calculated risks, starting with disclosure to those most likely to be supportive. It is key for the client to recognize that immediate acceptance is not realistic; families go through their own coming-out process and need time to adjust, a process that resembles Kubler-Ross's (1970) stages of grief (Emerson and Rosenfeld, 1996). It is also critical that the transgender individual keeps the communication channels open, even if the relative or friend is less than supportive. For some clients this is difficult, because they hunger for and deserve acceptance, particularly from their family and friends, yet it may not be readily available until later. Therefore, in the interim, support from the therapist and peers is crucial; the therapist and peers also play a vital role as a sounding board to help put reactions from family and friends in perspective.

Partners must be included in therapy as early as possible. If the client has children, it is optimal if the client and his or her partner can be united and together as parents inform the children. Partners and children may need their own therapist to support them through this transition. The paradigm shift from dichotomy to diversity means that, rather than having to come to terms with, for example, their husband and father being a ''woman'', they now need to learn about and adjust to their husband and father being transgender, which appears to provide greater room for acceptance. Nev-

ertheless, partners may question their own sexual identity or worry about how their relationship will be perceived and about the associated stigma. Inclusion in therapy of family of origin members and friends can be invaluable. Not only is the family oftentimes in need of support and resources that therapy can provide, but a loved one's disclosure and the subsequent crisis often is an opportunity for growth and strengthening of family relationships and friendships that can be facilitated through therapy.

Advocating for the client

Prior to and during the RLE, the therapist can fulfill a number of advocacy roles. These include providing assistance for legal changes in name and sex (usually in the form of supporting documentation), health insurance coverage, and consultation and training in school or workplace to facilitate changes in gender role.

Because of the increased visibility of transgender people, more and more individuals now come forward in childhood or adolescence, with some requesting puberty-delaying hormones (Cohen-Kettenis and Pfaefflin, 2003). While this is a welcoming development in terms of early intervention, it is important not to preclude transgender identity exploration. As a result of the still-predominant binary gender paradigm, once families recognize that it is unlikely their child will grow up to be a typical boy or girl, they may inadvertently apply pressure for the child to conform to being a member of the other sex (i.e., a typical girl or boy), whereas it may very well be that the child's authentic gender identity lies outside of this dichotomy. In light of the greater understanding of gender diversity and the need for exploration as a normal part of gender and sexual development, the decision to change gender roles in school must not be taken lightly. A child or youth can explore gender identity in many ways before considering a gender—role change in school (e.g., at home, through hobbies or by involvement in gay, lesbian, bisexual and transgender youth organizations and support groups). Following such exploration, when transgender feelings are persistent and the child or youth experiences significant distress associated with the gender role assigned at birth, a transition in school may be indicated. The role of the therapist is to evaluate such a possible transition, counsel the youth and family in making a fully informed decision and, subsequently, support that decision. This role may also include consultation and training in the school.

For adult clients, coming out in the workplace is usually the last step in transitioning to living full-time in the desired gender—role. This step needs to be timed appropriately in the pacing of the entire coming-out and transition process. Social support must be in place before confronting this step, which may be particularly risky as it involves the client's livelihood. Fortunately, many states and countries now have human rights legislation that protects transgender people from employment discrimination. However, even in the absence of that protection, when handled responsibly, the vast majority of gender—role changes on the job are successful as a result of careful planning and execution.

The therapist plays an important role in coaching the client through a workplace transition. The process begins with the client informing someone at work, usually his or her immediate supervisor and/or a member of the human-resources staff. The therapist assists the client in identifying the most appropriate person to disclose to and what to say (e.g., through role play). It is crucial that the client does not become both the orchestrator and the subject of the transition process; rather, the employer must coordinate this process. Typically, employers have little or no experience with gender—role changes on the job and they may lean on the transgender employee to take the lead. However, the transgender employee is supposed to be the one to be accommodated, not the one to plan and execute the accommodation. Moreover, if any difficulties are encountered, the transgender employee may be blamed for what went wrong. It is much better for the client to direct the employer to resources, preferably a consultant (which can be the therapist) to work with the employer and employee to develop a well thought-through transition plan.

This plan typically includes disclosure (verbally by the transgender employee) and training of management as well as immediate coworkers (by the consultant) that is consistent with existing sexual harassment and equal opportunity policies, executed in a timely fashion so as not to let anxiety build. Coworkers have a right to their own attitudes and values; however, they cannot bring these into the workplace and create a hostile environment for the transgender employee. In turn, the transgender employee needs to observe boundaries and not share too much personal information to supportive coworkers in the workplace, as others might overhear this and feel that there is a double standard with regard to what attitudes and values can be voiced. It is better for the transgender employee to share that information, if appropriate, outside of the workplace. One area that is often the source of anxiety for coworkers is the use of restrooms. Whereas it is most appropriate for the transgender person to use the restroom consistent with his or her new gender—role, it may be wise for the transgender employee to temporarily use a designated private bathroom until such time that the workplace has fully adjusted to the change (usually no more than three to six months).

Addressing intimate relationships and sexuality

Once greater comfort with gender identity and expression has been achieved, the third phase of transgender-specific therapy begins, where the emphasis shifts toward intimacy, including dating as a transgender person, relationships, and sexuality. Due to their stigmatized identity, transgender individuals may struggle with fears of abandonment or feelings of being unlovable. Clients need encouragement and counseling as to when and how to disclose or discuss their transgender identity in dating relationships.

Transgender people may be sexually oriented towards men, women, transgender people or all of the above. In a recent national study of the United States transgender population ($N = 1{,}229$), 27% of male-to-female transgender persons reported being attracted to men, 35% to women, and 38% to both men and women; 55% of female-to-male transgender persons reported being attracted to women, 10% to men, and 35% to both women and men. These data mean that, for some, coming out as transgender is accompanied by coming out as gay, lesbian or bisexual (Coleman and Bockting, 1988; Coleman et al., 1993; Devor, 1997;

Feinbloom et al., 1976; Lawrence, 2005). Beyond heterosexual and homosexual sexual scripts, therapy can assist transgender clients in exploring their unique transgender sexuality. This may include developing transgender-specific sexual language (e.g., to refer to genitals altered by hormone therapy and/or surgery); confronting myths and fears surrounding sexual roles and functioning; fostering comfort and skill in masturbation, and acceptance of transgender-specific sexual fantasies; exploring sensation and orgasm; and coping with feelings of vulnerability in sexually-intimate relationships (Bockting, 2003; Bockting et al., 2005b).

Providing aftercare

Transgender coming out is a lifelong process (Bockting and Coleman, 2007). Hence, for those who opt for surgery, treatment does not end there. The therapist can serve as an ongoing resource for assistance with coming out, intimate relationships, sexual functioning, resurfacing of grief over lost time, aging, and other life transitions or mental-health concerns. These life transitions may continue to challenge the client positively to arrive at a deeper level of acceptance of transgender identity. Eventually, being transgender becomes an integral part of the client's self, a part to be proud rather than ashamed of, but no longer the only or necessarily most important part of overall identity.

Conclusion

The public has long been fascinated by the phenomenon of transsexualism and the physical aspects of a ''sex change''. However, the reality is that the transgender coming-out process is first and foremost a psychosocial process, during which medical intervention through hormone therapy and surgery are merely options utilized by some transgender individuals to achieve greater comfort with self and body. Moreover, when pursuing the desire to ''change sex'', most transsexual individuals eventually attain an identity and experience that is distinct from those of nontransgender women and men.

Psychotherapy can play an invaluable role in supporting transgender individuals in addressing the impact of stigma, confronting internalized transphobia, exploring their gender identity and sexuality, and achieving comfort and fulfillment. In addition, all-important relationships with partners, children, parents, siblings, and friends are affected in this process and therapy can facilitate the necessary adjustment to the client's new gender role, as well as deepen intimacy and strengthen family relationships. Challenges for the therapist include managing the gate-keeping dynamic, as evaluation and oftentimes psychotherapy are required to access hormone therapy and/or chest/breast or genital-reconstructive surgery. However, when handled ethically and responsibly, this gate-keeping role can serve to facilitate further growth and improve quality of life.

The RLE has been credited for the scarcity of regrets among transsexual individuals who have had genital-reconstructive surgery (Kuiper and Cohen-Kettenis, 1998; Pfaefflin, 1992). However, in reality, little empirical evidence supporting this claim exists (Lawrence, 2001, 2003). In addition, the length of the RLE has been disputed; although it used to be two years, the current standards of care for gender-identity disorders require a minimum of one year (Meyer et al., 2001) and others advocate for less than that or question the value of the RLE all together (Lawrence, 2001). The value of the RLE is an empirical question that demands further study. In addition, more research is needed to evaluate the role of psychotherapy in facilitating the coming-out process and promoting resilience among this population.

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Appendix A

Appendix A: Cover letter explaining the treatment process to clients

Dear Client:

Welcome to Transgender Health Services at the Center for Sexual Health (CSH) of the University of Minnesota Medical School. We believe the transgender community is diverse, and includes individuals who identify as transgender, transsexual, crossdresser, bigender, drag queen, drag king, genderqueer, female impersonator, etc. and their families. Our Center welcomes all of you.

CSH believes that a transgender identity is to be celebrated. No matter how you experience your gender identity, we can provide support and guidance on your journey. Of course, we recognize that hormones and/or surgery are definitely goals for some clients; some people have other goals. Given the way that society sees gender as fixed and unchangeable, it is not unusual for transgender people to face many challenges, such as low self esteem, coming out, name and other document changes, shame, secrecy, and fear of rejection. Our approach sees psychotherapy as integral to helping you with these challenges.

CSH provides a variety of services. We have psychiatrists, psychologists, and a physician on staff who provide clinical services. We are committed to working with insurance providers to obtain coverage for treatment needs. We offer consultation on coming out at work, transgender sensitivity training, education of health and social service providers, and expert witness testimony on behalf of clients.

Here's what to expect when you go to CSH for your first two appointments: initially, you will fill out some routine paperwork and meet with your therapist about why you are seeking care. Your therapist will want to get to know you. The two of you will discuss aspects of your life, such as your family, life goals, general health, and any issues of substance abuse you may have.

We recognize that some of this information may be uncomfortable for you to share. In order to provide the quality of care you deserve, these are things that we need to discuss. We will work hard to make it as comfortable for you as possible.

After the first or second session, it is typical for all clients of CSH to complete a self-esteem scale, a sexual functioning inventory, a psychological test, and several paper and pencil measures about their history. These evaluations are useful to plan your treatment, and in some cases are required to obtain health insurance coverage for hormone therapy or transgender surgery.

If you are interested in pursuing hormones and/or surgeries, CSH has established guidelines that are based on the World Professional Associations's Standards of Care. If you do not have the Standards of Care, you can request them from CSH or access them online at www.wpath.org.

These are general guidelines. Ultimately, decisions to support hormone therapy or surgery are made on an individualized basis. While participating in our services, we ask that you respect the agreement not to take hormones or obtain chest/breast or genital reconstructive surgery (as defined by the World Professional Association for Transgender Health) without the support of our staff. If you feel that you need to deviate from these guidelines, please discuss this with your therapist as soon as possible. If you are already taking hormones, and you are not sure whether you meet the Standards of Care, please discuss this with your therapist as well.

These guidelines were co-authored by CSH staff and the Transgender Community Advisory Board, which is comprised of members of the local transgender community. If you have any questions about these guidelines, please address them with your therapist or any other CSH staff.

Sincerely,

Walter Bockting, PhD
Coordinator, Transgender Health Services
For the staff and advisory board of the Center for Sexual Health

Appendix B

Name: _____ Medical Record #: _____
Date of staff review: _____ Today's date: ___/___/_____

Appendix B: Guidelines for Adult Hormone Therapy

The Center for Sexual Health recognizes that individuals have varying needs when pursuing hormone therapy. CSH follows the World Professional Association for Transgender Health's Standards of Care (WPATH SOC). The SOC provide guidelines for both adults and youth. You can find the WPATH SOC on the web at www.wpath.org, or request a copy from your therapist. This document is for adults, but CSH also provides services for transgender youth. Section A and B are criteria taken directly from the WPATH SOC. Section C is required to ensure your physical health. Section D is grounded in CSH's approach to transgender care, and can be adapted to your situation with the help of your therapist.

A. The WPATH SOC lists 3 ELIGIBILITY CRITERIA for hormone therapy for adults:

1. Age 18 years. Your age: _____

2. Demonstrable knowledge of what hormones medically can and cannot do and their social benefits and risks.

CSH interprets this to mean:

- CSH encourages you to inform yourself about effects and side-effects of hormones. Dr. Sheila Kirk's booklets on feminizing and masculinizing hormonal therapy for the transgendered, and Gianni Israel and Dr. Donald Tarver's book entitled *Transgender Care* are good resources. You can also use the web and your community members to find information. If you have any questions, discuss these with our physician on staff, Dr. Jamie Feldman. You will be asked to sign an informed consent form for hormone therapy.

*Informed consent form signed on: ___/___/_____

3. Either:

a) A documented real-life experience of at least three months prior to the administration of hormones;

OR

b) A period of psychotherapy of a duration specified by the mental health professional after the initial evaluation (usually a minimum of three months).

CSH interprets this to mean:

- CSH's initial evaluation consists of one to two sessions; for details, see the introductory letter. After you have completed this evaluation, the period of psychotherapy (usually a minimum of three months) begins.

*Starting date of real life experience: ___/___/____

*Starting date of psychotherapy: / /

B. The WPATH SOC lists 3 READINESS CRITERIA for hormone therapy for adults:

1. The patient has had further consolidation of gender identity during the real-life experience or psychotherapy.

CSH interprets this to mean:

- To have gained some experience spending time in the desired gender role (e.g. socializing with friends, going out to eat, etc.). This guideline is not about how well you "pass" as your chosen gender role; rather, CSH wants you to experience what it will mean to you to be out in the world as a transgender person.

*Accomplished: _____

2. The patient has made some progress in mastering other identified problems leading to improving or continuing stable mental health (this implies satisfactory control of problems such as sociopathy, substance abuse, psychosis, and suicidality).

CSH interprets this to mean:

- If your substance use seems to be persistent and unmanageable, to have completed a chemical dependency evaluation, to have followed through with the recommendations of the evaluator, and, if applicable, to have established at least three months of sobriety.

*Date of sobriety: ___/___/____

- If you have significant current psychiatric problems, to have completed a recent psychiatric evaluation and followed through with the recommendations of the psychiatrist.

*Name of treating psychiatrist:_____

- To have updated psychological testing completed at the Center for Sexual Health between 1 and 3 months prior to our staff's review of your request for hormone therapy. This testing includes the Transgender Identity Survey, Minnesota Multiphasic Personality Inventory (2nd edition), the Tennessee Self Concept Scale, the Derogatis Sexual Functioning Inventory, and others as recommended by your therapist.

TIS: _____ MMPI-2: _____ TSCS: _____
DSFI: _____ Other: _____

3. The patient is likely to take hormones in a responsible manner.

Guidelines for Adult Hormone Therapy

C. PHYSICAL HEALTH CRITERIA required by CSH:

- If you have physical problems that pose a risk for hormone therapy, to have discussed these with your physicians and followed through with their recommendations.

  *Nature of physical concerns: _____

  *Names of treating physicians: _____

- To have had a complete physical examination and complete blood chemistry done within three months of the staff's review of your request for hormone therapy, with the results made available to your therapist at the Center for Sexual Health. We prefer that you have this done by our physician on staff, Dr. Feldman.

  *Date of physical: ___/___/____

D. Strongly encouraged (but not required) guidelines from CSH:

- To have considered participating in group therapy with other transgender clients at the Center for Sexual Health. Group therapy is designed to provide support, to meet other transgender people, and to discuss issues that are important to living as a transgender person.

  *Group therapy: _____Yes _____No

- To have established a network of social support consisting of people you can confide in. We recommend that your support includes at least one friend within and one friend outside of the transgender community. You are encouraged to include selected members of your support network in therapy.

  *First names of closest support persons: _____

  _____

- To have seriously considered informing your family (e.g., partner, children, parents, siblings, and other significant others) about your transgender identity and your hormone therapy. Your therapist will discuss with you the risks as well as the rewards of informing your family. If your family is willing, you are encouraged to include them in your therapy. This does *not* imply that your family needs to agree with your decision, rather, it provides an opportunity for family to express their feelings about your decision.

  *Accomplished: _____

- To have considered how you may feel about the ways hormone therapy will potentially change your sexual functioning (erectile function, desire, etc.) and relationships (attractions, differences in levels of sexual desire, etc.).

  *Discussed and considered with therapist: _____

  _____

- During the first six months of hormone therapy, you are encouraged to continue psychotherapy with a minimum frequency of once a month to monitor your adjustment to the effects of hormone therapy. Since this period of time can be full of changes, many people find ongoing psychotherapy helpful.

  *Dates of therapy since onset of hormone therapy:

  _____

E. Disclosure requirement

- If you are in a primary relationship, the Center for Sexual Health encourages you to have informed your partner of the effects and the possible side-effects and risks of hormone therapy, and to have discussed the potential impact of hormone therapy on your relationship. If you are legally married, this is required, and you must have a signed informed consent form. We encourage you to accomplish this by including your partner in visits to your therapist and physician.

  *Date of receipt of signed consent form: __/___/____

Why does CSH require this?

- Ethical responsibility to inform your spouse.
- Obtaining this consent protects both you and CSH in the event of any litigation (e.g., divorce or child custody).

Appendix C

Name: _____ PHS #: _____
Date of staff review: _____ Today's date: ___/___/_____

Appendix C: Guidelines for Transgender Surgeries

The Center for Sexual Health (CSH) recognizes that individuals have varying needs when pursuing surgery. For example, some may want chest/breast surgery and no genital surgery, others may want both. CSH follows the World Professional Association for Transgender Health's Standards of Care (WPATH SOC). You can find the WPATH SOC on the web at www.wpath.org, or request a copy from your therapist. Both WPATH and CSH treat chest/breast surgeries for the purposes of transition as different from genital surgeries. Section A outlines CSH's approach to chest/breast surgeries. For genital surgery, sections B and C are required, because they are taken directly from the WPATH SOC. Section D is grounded in CSH's approach to transgender care and can be adapted to your situation with the help of your therapist.

A. WPATH SOC says the following about chest/breast surgeries:

"Breast augmentation and removal are common operations, easily obtainable by the general public for a variety of indications. Reasons for these operations range from cosmetic indications to cancer. … The performance of breast operations should be considered with the same reservations as beginning hormonal therapy. Both produce relatively irreversible changes to the body.

The approach for male-to-female patients is different than for female-to-male patients. For female-to-male patients, a mastectomy procedure is usually the first surgery performed for success in gender presentation as a man; and for some patients it is the only surgery undertaken. … Female-to-male patients may have surgery at the same time they begin hormones. For male-to-female patients, augmentation mammoplasty may be performed if the physician prescribing hormones and the surgeon have documented that breast enlargement after undergoing hormone treatment for 18 months is not sufficient for comfort in the social gender role."

CSH interprets this to mean:

- For female-to-male chest surgery, no minimum period of prior hormone therapy is required.
- If you are a male-to-female client taking hormones, it is recommended that you wait 18 months (or until no further growth can be expected) to allow for hormone-induced breast growth before requesting a referral for breast augmentation surgery. You should discuss this with your doctor.
- If you are a female-to-male client, CSH requires that you complete the 3-month therapy period **or** have lived for 3-months in your preferred gender before having chest surgery. It is not necessary to take hormones prior to having chest surgery.
- CSH considers chest/breast surgery to be sex reassignment surgery.
- You will be asked to sign an informed consent form for chest/breast surgery.

*Informed consent form signed on: ___/___/_____

B. WPATH defines the following eligibility criteria for genital surgeries:

1. Legal age of majority in the patient's nation.

2. Usually 12 months of continuous hormonal therapy for those without a medical contraindication.

CSH interprets this to mean:

- To have been on hormones for a minimum of 12 months prior to genital reconstructive surgery. This guideline only applies to those pursuing both hormone therapy and sex reassignment surgery.

*Starting date of hormone therapy: ___/___/_____

3. 12 months of successful continuous full time real-life experience.

CSH interprets this to mean:

- CSH understands that there may be certain circumstances where it may be unsafe or unhealthy for you to present in your preferred gender role. You should discuss this with your therapist.
- "Passing" is not a measure of success. Rather, success is being satisfied with living as your preferred gender.

*Starting date of real life experience: ___/___/_____

continue to page 2 . . .

Guidelines for Transgender Surgeries

B. WPATH defines the following eligibility criteria for genital surgeries: (continued)

4. If required by the mental health professional, regular responsible participation in psychotherapy throughout the real-life experience at a frequency determined jointly by the patient and the mental health professional. Psychotherapy per se is not an absolute eligibility criterion for surgery;

CSH interprets this to mean:

- While CSH does not *require* therapy during the real life experience, we do require that you have updated psychological testing completed at the Center for Sexual Health between 1 and 3 months prior to our staff's review of your request for sex reassignment surgery. This testing includes the Minnesota Multiphasic Personality Inventory (2nd edition), the Tennessee Self Concept Scale, the Derogatis Sexual Functioning Inventory, and others as recommended by your therapist.

MMPI-2: _____ TSCS: _____ DSFI: _____ Other: _____

5. Demonstrable knowledge of the cost, required lengths of hospitalizations, likely complications, and post surgical rehabilitation requirements of various surgical approaches;

CSH interprets this to mean:

- CSH encourages you to be an informed health care consumer. You will also be asked to sign an informed consent form for surgery.

*Informed consent form signed on: ___/___/_____

6. Awareness of different competent surgeons.

CSH interprets this to mean:

- CSH recommends that you get up-to-date information on sex reassignment surgery by contacting at least two competent surgeons. Your therapist can help you with a list of suggested surgeons. You are strongly encouraged to thoroughly evaluate your options, doing your own research and talking to others in the transgender community about their experiences.

*Date discussed with therapist: ___/___/_____

C. WPATH defines the following readiness criteria for genital surgeries:

1. Demonstrable progress in consolidating one's gender identity;

CSH interprets this to mean:

- That you are comfortable with your gender identity.

2. Demonstrable progress in dealing with work, family, and interpersonal issues resulting in a significantly better state of mental health (this implies satisfactory control of problems such as sociopathy, substance abuse, psychosis, suicidality, for instance).

CSH interprets this to mean:

- That you have developed skills to help you face the challenges of work, family, and home, while maintaining stable mental health.

D. Strongly encouraged (but not required) guidelines from the Center for Sexual Health

- You should have completed section D of the Guidelines for Hormone Therapy (but not necessarily take hormones).

*Completed: ___YES ___NO

- CSH encourages you to continue regular (at least monthly) participation in therapy throughout the real life experience.

*Dates of therapy during real life experience: _____

_____

E. Limitation on Recommendation and Disclosure Requirement

- The Transgender Health Services staff's recommendation for sex reassignment surgery is limited and valid for one year from the date of the staff's review. In order to extend the recommendation, you will need to consult with your therapist for a brief update on your situation. Unless your situation has radically changed, this is only a formality.

*Dates of update: _____

- If you are in a primary relationship, the Center for Sexual Health encourages you to have informed your partner of the effects and the possible side-effects and risks of genital or chest/breast surgery, and to have discussed the potential impact of surgery on your relationship. If you are legally married, this is required, and you must have a signed informed consent form. We encourage you to accomplish this by including your partner in visits to your therapist and physician.

*Date of receipt of signed consent form: ___/___/_____

Why does CSH require this?

- Ethical responsibility to inform your spouse.
- Obtaining this consent protects both you and CSH in the event of any litigation (e.g., divorce or child custody).

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